Indiana PERF
Public Employees' Retirement Fund

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

State Form 51806 (R / 8-08)

* This agency is requesting disclosure of your Social Security Number in accordance with IRS Code 3405; disclosure is mandatory and this form will not be processed without it.

I, _____, hereby authorize the Indiana Public Employees' Retirement Fund (PERF) to release confidential information and membership records related to my PERF account to the following third party:

Name	Relationship
Address at time of death (*number and street, city, state, and ZIP code*)	

The extent of this authorization is as follows (*check one*):

☐ Disclosure shall be unlimited and shall include all confidential membership information and records.

☐ Disclosure shall be limited to the following specific types of information:

_____

_____

I understand that, pursuant to IC 5-10.2-2-17, PERF records of individual members and membership information are confidential, except for the name and years of service of the PERF member. I further understand and agree that by signing this Authorization to release confidential information ("Authorization"), I am waiving the legal protections provided by this statute to the extent I have directed above.

I understand and agree that any cancellation or modification of this Authorization must be in writing, and that this Authorization shall remain valid for one (1) year after the date of my signature or until a written cancellation or modification is received by PERF. A photocopy or facsimile of this Authorization shall be as effective and valid as the original.

By signing below, I release and hold harmless PERF, its agents, and its employees from any and all liability, charges, complaints, claims, causes of action, and damages of any kind which might be asserted in connection with the release of confidential information described herein.

Signature of member	Date (*month, day, year*)
Social security number of member *	
Signature of witness	Date (*month, day, year*)
Printed name of witness	